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a. Hospital-based physicians who may not bill separately on a fee for service basis

i. A physician whose salary is included in the hospital's cost report for direct patient care may not bill separately on a fee-for-service basis.

ii. A teaching physician who provides direct patient care may not bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution includes a component for treatment services.

b. Hospital-based physicians who may bill separately on a fee-for-service basis

i. A physician whose salary is not included in the hospital's cost report for direct patient care may bill separately on a fee-for-service basis.

ii. A teaching physician who provides direct patient care may bill separately on a fee-for-service basis if the salary paid to the teaching physician by the hospital or other institution does not include a component for treatment services.

iii. A resident may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she is permitted to and does bill private patients and collect and retain the payments received for those services.

iv. A hospital-based specialist who is salaried, with the cost of his or her services included in the hospital reimbursement costs, may bill separately on a fee-for-service basis when, by the terms of his or her contract with the hospital, he or she may charge for professional services and do, in fact, bill private patients and collect and retain the payments received.

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v. A physician holding a nonteaching administrative or staff position in a hospital or medical school may bill separately on a fee-for-service basis to the extent that he or she maintains a private practice and bills private patients and collects and retains payments made.

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2. Charges are to be submitted on a fee-for-service basis only when the physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, it means presence in the operating room, performing or supervising the major phases of the operation, with full and immediate responsibility for all actions performed as a part of the surgical treatment.

IV. Basic Methodology for Determining DRG Prospective Payment Rates

09/91 A. DRG Classification and Weighting Factors

1. DRG Classification

== 10/93

The Department will utilize the DRG Grouper, as described in Section B.5. of Chapter XV., to classify inpatient hospital discharges by diagnosis related groups (DRG's) as defined by federal regulation for the Medicare Program (42 CFR 412) with modifications deemed appropriate due to the differences in the Medicare and Medicaid patient populations and Illinois Medicaid policy.

2. DRG Weighting Factors

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a. Except as provided in Sections A.2.b. through A.2.e. of this Chapter, the Illinois Medicaid weighting factor for each DRG shall equal the Medicare weighting factor, as described in Section B.5.b. of Chapter XVI., for that group, in effect on September 1, 1992, multiplied by a fraction, the numerator of which is the Medicaid geometric mean length of stay and the denominator of which is the Medicare geometric mean length of stay for that group. In making that calculation, the Department shall:

i. Use the Medicare geometric mean length of stay for each diagnostic-related group as determined by the Health Care Financing Administration of the United States Department of Health and Human Services.

ii. Calculate the Medicaid geometric mean length of stay for each diagnostic-related group using the same methodology employed to calculate the Medicare geometric mean length of stay and using data obtained from the Illinois Health Care Cost Containment Council or the Department's data bases.

b. The Illinois weighting factors for neonatal discharges (Medicare-defined DRG's 385-391 and Illinois-defined DRG's for Level III perinatal centers) shall be the product of the ratio of the mean cost per discharge (defined below) of the given DRG to the mean cost per discharge for DRG 391 (normal newborn) and the Medicare scaling factor (defined below), such that the Illinois and Medicare weighting factors for DRG 391 are the same.

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i. Mean cost per discharge, for any DRG, is defined as the sum of the product of charges, as reported by a hospital on claims paid by the Department, less costs for capital, direct and indirect medical education, updated to the current rate year using the national hospital market basket price proxies (DRI) and the hospital's cost to charge ratio, as derived from the hospital's most recent audited cost report, divided by the number of discharges for that DRG.

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ii. Medicare scaling factor is defined as the Medicare weighting factor for DRG 391 (normal newborns).

c. The Illinois weighting factors for psychiatric discharges (DRG's 424-432) shall be computed as specified in Sections A.1. and A.2. of this Chapter except, prior to computing the Medicaid geometric mean length of stay for those DRGs, all lengths of stay longer than three (3) days are to be set at three (3) days.

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d. The Illinois weighting factors for DRGs that will not be paid through the DRG PPS are zero (0.0000). Those include DRG 103, heart transplant; DRG 436, alcohol/drug dependence with rehabilitation therapy; DRG 462, rehabilitation; DRG 480, liver transplant; DRG 481, bone marrow transplant; DRG 495, lung transplant.

e. Except for DRG's otherwise specified in Sections A.2.b. through A.2.d. of this Chapter, the Illinois weighting factors for DRG's for which available historic discharge data are sparse, fewer than 100 records, shall be computed using an alternate methodology.

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i. For rate periods beginning on or after October 1, 1992, for those DRG's with 32 or more records available, the Illinois weighting factor shall be set at the midpoint between the weight calculated using the methodology in Section A.2.a. of this Chapter and the Medicare weighting factor, as described in Section B.5.b. of Chapter XVI.

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ii. For those DRG's with fewer than 32 records available, the Illinois weighting factor shall be set equivalent to the Medicare weighting factor, as described in Section B.5.b. of Chapter XVI.

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f. For the rate periods, as described in Section B.2.b. of Chapter XV, the DRG weighting factors shall be adjusted by a factor, the numerator of which is the statewide weighted average DRG base payment rate in effect for the base period, as described in Section B.2.a. of Chapter XV, and the denominator of which is the statewide weighted average DRG base payment rate for the rate period, as described in Section B.2.b. of Chapter XV. For this adjustment, DRG base payment rate means the product of the PPS base rate, as described in Section B.2.c. below, and the indirect medical education factor, as described in Section C.3. of Chapter VII.

3. Assignment of Discharges to DRG's

The Department will establish a methodology for classifying specific hospital discharges within DRGs which ensures that each hospital discharge is appropriately assigned to a single DRG, based on essential data abstracted from the inpatient bill for that discharge.

a. The classification of a particular discharge will, as appropriate, be based on the patient's age, sex, principal diagnosis (that is, the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital), secondary diagnoses, procedures performed, and discharge status.

b. Each discharge will be assigned to only one DRG (related, except as provided in Section A.3.c. below, to the patient's principal diagnosis) regardless of the number of conditions treated or services furnished during the patient's stay.

c. When the discharge data submitted by a hospital show a surgical procedure unrelated to a patient's principal diagnosis, the bill will be subject to prepayment review for validation and reverification. The Department's DRG classification system will provide a DRG, and an appropriate weighting factor, for cases for which the unrelated diagnosis and procedure are confirmed.

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4. Review of DRG Assignment

   a. A hospital has 60 days after the date of the remittance advice indicating initial assignment of a discharge to a DRG to request a review of the assignment. The hospital may submit additional information as a part of its request.

   b. The Department shall review the hospital's request and any additional information and decide whether a change in the DRG assignment is appropriate. If the Department decides that a higher-weighted DRG should be assigned, it must request the Department's peer review organization to review the case to verify the change in DRG assignment.

   c. Following the 60-day period described in Section A.4.a. above, the hospital may not submit additional information with respect to the DRG assignment or otherwise revise its claim.

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== 10/93 B. Illinois Rates for Admissions

== 10/93 1. Reimbursement to hospitals for claims for admissions occurring prior to October 1, 1992, shall be calculated and paid in accordance with State plans governing the time period when the services were rendered. With the exception of those payments described in Chapter X., the payments shall be effective for admissions on and after October 1, 1992, subject to the provisions of Section A.2.

07/92 The payments described in Chapter X. shall be effective for admissions provided on or after September 1, 1991, with the exception of provisions that relate to pancreas or kidney-pancreas transplants. Provisions relating to pancreas or kidney-pancreas transplants shall be effective for admissions on and after July 1, 1992.

2. Determining Prospective Payment Rates

== 10/93 a. Federal/Regional Blended Rate Per Discharge

== 10/93 i. Except as specified in Section B.2.a.ii. below, the Department shall reimburse hospitals for inpatient services at the federal/regional blended rate per discharge for the Medicare Program, which includes the hospital-specific portion as described in B.2.b. below, if applicable, and as computed by the PPS Pricer, as described in Section B.6. of Chapter XV.

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ii. In the case of a hospital that was not determined by the Department to be a rural hospital at the beginning of the rate period described in Section B.2.a. of Chapter XV., but was subsequently reclassified by the Department as a rural hospital, as described in Section B.3. of Chapter XV, on July 15, 1993:

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(A) Effective with admissions occurring on October 1, 1993, and for the duration of the rate period described in Section B.2.a. of Chapter XV., the Department shall recompute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect on September 1, 1992, under the Medicare Program.

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(B) Effective with admissions occurring on or after the rate periods described in Section B.2.b. of Chapter XV., the Department shall compute such hospital's DRG PPS payment rate using the rural hospital federal/regional, rural wage adjusted, blended rate per discharge in effect 90 days prior to the date of admission, under the Medicare Program.

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b. Hospital Specific Portion

The hospital-specific portion is defined as the specific status and any applicable add-ons under the Medicare Program in recognition of sole community hospitals, rural referral centers, Medicare dependent hospitals and rural hospitals deemed urban.

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10/93 c. DRG PPS Base Rate

The DRG PPS base rate shall be defined as the sum of the amounts computed under Section B.2.a. and B.2.b., multiplied by the Illinois weighting factor weight assigned to the DRG into which the case has been classified.

10/93 d. Payment Adjustments

==07/95 In addition to the DRG PPS base rate defined in Section B.2.c. of this Chapter, hospitals shall receive applicable outlier adjustments, in accordance with Chapter V., applicable adjustments for capital costs in accordance with Chapter VII., applicable adjustments for disproportionate share and various specific inpatient payment adjustments, in accordance with Chapter VI. and Chapter XV.

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3. Application of Upper Payment Limits

The Department shall adjust each of the prospective payment rates determined under Sections B.1. and B.2. of this Chapter (with the exception of disproportionate share payment adjustments made in accordance with Chapter VI.C.7.) to ensure that aggregate payments do not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles, in compliance with 42 CFR 447.272, Application of Upper Payment Limits.

V. Payment For Outlier Cases

09/91 A. General Provisions

== 10/93 1. Except as provided in Sections A.2. and A.3, the Department provides for additional payment, approximating a hospital's marginal cost of care beyond thresholds specified by the Department, to a hospital for covered inpatient hospital services furnished to a Medicaid client, if either of the conditions in the following Sections A.1.a. or A.1.b. apply:

== 10/93 a. The client's length of stay (including up to three administrative days) exceeds the day outlier threshold, determined by the Department, for the appropriate applicable DRG.

== 10/93 i. For the rate period described in Section B.2.a. of Chapter XV., the threshold is set at the lesser of the geometric mean length of stay plus 27 days, or the geometric mean length of stay plus three standard deviations.